



Dermatology Associates of Northern Virginia, Inc.

Medicare Patient Information

Today's Date: ___/___/___

Name: ___ First ___ M.I. ___ Last ___

SSN ___ Date of Birth: ___/___/___ Age: ___ Sex: M F

Race ___ Ethnicity ___ Preferred Language ___

Clinical Quality Measures: Height ___ Weight ___

Tobacco Use: NO YES If yes, smoker or smokeless tobacco (circle one)

CONTACT INFORMATION

Mailing Address: ___ City ___ State ___ Zip ___

Home Phone: () ___ Alternative Phone: () ___

E-mail Address: _____

INSURANCE COVERAGE

Primary Insurance Carrier: ___ ID#: ___ GROUP#: ___

Secondary Insurance Carrier: ___ ID#: ___ GROUP#: ___

Name of Policy Holder (insured person) ___ Relationship to Patient: ___

Policy Holder Date of Birth: ___/___/___

REFERRING PHYSICIAN

Name: ___ Specialty: _____

EMERGENCY CONTACT

(In Case of Emergency)

Relationship _____ Phone #: () _____

Please Sign So We May Have Your Medicare Authorization On File:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date: ___/___/___ Signature: _____

Please Sign So We May Have Your Supplemental Authorization On File:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: ___/___/___ Signature: _____

CONTINUED INFORMATION ON BACK

Payment Policy

Medicare: We are participating providers of the Medicare Program. We will accept assignment on all claims. Patients are responsible for meeting their annual \$110.00 deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers

Please present Medicare and secondary insurance card(s) and photo ID to the receptionist so copies may be made.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event that your account must be turned over to collections, the patient responsibility is the actual cost of collections including but not limited to court/attorney fees. In the event that an appointment is not cancelled within 24 hours, you will be charged up to a \$50.00 fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ **Date** ____/____/____

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct, I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare part B benefits to the social security administration and healthcare financing administration).

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing of my insurance claims.

A copy of this authorization may be used in the place of the original.

I understand and agree that I am financially responsible for all charges not paid by my insurance company.

This authorization may be revoked by either me or my insurance carrier at any time in writing.

Patient or Responsible Party Signature _____ **Date** ____/____/____

I understand that in certain circumstances Medicare may decide that appropriate medical services are not medically reasonable or necessary under the Medicare law. I agree to be personally responsible for payment of these charges.

Patient or Responsible Party Signature _____ **Date** ____/____/____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been given a copy of the Notice of Privacy Practices uses and disclosures.

Dermatology Associates of Northern Virginia may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or other healthcare operations.

Dermatology Associates of Northern Virginia may mail to my home or other designated locations any items that assist the practice in carrying out treatment, payment or other healthcare operations.

By signing this form, I am consenting to Dermatology Associates of Northern Virginia's use and disclosure of my protected health information to carry out treatment, payment and other healthcare operations.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian